

## P.O. Box 8747 • BOSTON, MA 02114-8747 (617) 727-2310 www.mass.gov/gic

## Insurance Enrollment and Change Form (FORM -1)

01															
Insured's GIC-ID (usually Soc. Sec. #)  Sex: Male					Date of Birth De						pt. ID # or Agency/Division #				
			Female	,	/ /				/						
Name - Last First MI															
Addı	ess		☐ Th	is is a new a	ddress	City			S	tate	Z	ip Code			
	5	I 5		Luniosea			1					<u></u>			
Date Entered Service Bargaining Unit/Union Name HR/CM						/CMS or UMASS Employee ID #: Home Phone				Work Phone					
	/ /				( )						( )				
02 <u> </u>						LIFE, HEALTH AND LTD COVERAGE					Effective Date: / 01 /				
New Enrollment Change											Cancel Coverage				
90000	Basic Life Only										Long Term Disability (LTD)				
Cong Term Disability (LTD)  Annual Salary: \$ Health Insurance															
Basic Life and Health (Select one of the Health Plans below) Salary Effective Date://															
3															
Hea	Health Plan														
Hallon Select (HIVIO) (HIVIO) CIC. Has tes the result of the second of t															
	Harvard Pilgrim Independence (PPO) Tufts Health Plan Navigator (PPO) UniCare/Community Choice Family Harvard Pilgrim Primary Choice (HMO) Tufts Health Plan Spirit (HMO-type) (PPO-type)														
		New England (F		ivio, s <del></del>	- Tuito	ilouitii i it	ли Оринс (	invio typo				PPO-type)			
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	Automatic Increase	ondok ond.		Œ				amily Statu	ıs Chang	e				<del>)</del> :	
	Indicate Multiple Factor (1-8): Smoker Multiple Factor 2-8 times is allowed only with Automatic  Multiple Factor 2-8 times is allowed only with Automatic  Multiple Factor 2-8 times is allowed only with Automatic  Mon Automatic Increase — Family Status Change														
i	increase. Changing from Non			a E	Amou		ilicicasi	z — I alliliy	Status G	ialiye				er en tobacco	
Services.	medical form. <b>Non Automatic Increa</b> :	90			No mo	re than \$100	0 less than	annual salary	rounded do	wn to the		free	for the pa	st 12 months	
******	Amount S: an invariant service of the service of th														
	No more than \$1000 less than annual salary rounded down to														
	the nearest \$ 1,000	vious Name						New Name							
03 [	│ Name Change │ Pre	vious raunic						14CVV 14dillo							
	•				I F	AVE OF	ΔRSFNC	F	FOR GIC I	JSE ONLY:	Effect	ive Date:	/ 01	ı	
۰4۲	Leave Is: With	Day 🗀 Mith	out Pov			3172 01 /	TIDOLITO	· <b>-</b>	-		Loovo	Pay Status:	☐ Pai		
04 Leave Is: With Pay Without Pay Leave Type (You MUST Check one of the following):											Leave	ay Status.	□ rai	· · · · · · ·	
	you, " yo								ersonal Re	ason					
* Personal Illness Sabbatical										(for dep < age 3) Other					
	* Industrial accident	I	Suspension		N	lilitary									
	* Industrial Accident (with		(without pay), a	and Person	ıal IIIness	(without pay	y) leaves all	require the e	mployee to	submit a Fo	rm 11 to	the Group Ins	urance Co	mmission	
	with a letter from the age		<del>"</del>	bsence.			-1	7						,	
	Duration of Leave:	Start	Date /	/	Er	nd Date	/		Tex.			y on Payroll		/	
05	Return to Payroll Deducti	ion: First [	Day Back on Pa	yroll	/	/				FOR GIC US	E ONLY:	Effective	Date:	/ 01 /	
					IN	SURED (	CHANGE	S							
06	Retirement	Date	Retired	/	/	☐ ORP (Higher Ed Only) Fund Name:									
07	Transfer to another Agen	<b>cy N</b> ame	e of Agency Tra		·				Effective Date / /						
<sub>08</sub> [	Transfer from another Ag	<b>ency</b> Previo	Previous Agency								Effectiv	e Date	1	1	
09	Termination Coverage (if elected)	Termi	nation Reason	on Reason							Termina	ation Date	1	1	
	ooverage (ii ciccicu)	<u></u> 39	9 -Week Layoff	Coverage	☐ De	ferred Retire	ее 📋 С	OBRA (must c	omplete COB	RA application	-	-	contact car	rier for application)	
0	Deduction Authorization:   au Long Term Disability Insurance							•						provided setisfec-	
=	tory medical evidence of insura		a alac by Hot app	lying to bo		Long Tomic	ioubility (LIB	inourance vin	on mor ongio	o, may not	.pp., 101 L	.iD incurance	andrinavo	provided editions	
7	Health Insurance:   understa		•		-	•				•				to provided actic	
BE (	Optional Life Insurance: I und factory medical evidence of in	•			•	e msurance i	witen illst ei	gible, i may nu	сарріў іог о	increase in	у Ориона	i Life msurand	e unui i na	ve provided saus-	
Ш	At Retirement: I hereby certify	•	• •					overage as a i	etiree. I also	understand	that if I a	m Medicare e	ligible, I an	required to join	
U.B.	e one of the Group Insurance Commission's Medicare supplemental health plans to continue health coverage.														
ATU	Termination: I understand that by electing to continue coverage under COBRA or Conversion, I must complete and return the corresponding application in order for this coverage to go into effect.												nto effect.		
2	If you are applying for Health	n Insurance, be sure	to file a Form IDI	F to list fami	ily membe	rs.									
S   G	. 117.0	,			•										
	x						x								
	Signature of Applicant  CIC LISE ONLY Entered		Date	Verified			x Si	gnature of Au		icial ical Subdivi		Date			